Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN8ADA	A. BUILDING _____ B. WING _____	12/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE HOUSE I	57 VINE STREET RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comment Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 12/11/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven residential program beds for the treatment of abuse of alcohol and drugs. The census at the time of the survey was six. Six resident files and three employee files were reviewed. One discharged resident file was reviewed.	D 000		
D 231	NAC 449.144(1)(f) Medication The policies must require that: (f) There be documentation in the client ' s record of the name of the medication, dose, route of administration, time and name of the person observing the self-administration or the licensed staff member who administered the medication. This Regulation is not met as evidenced by: Surveyor: 28380 Based on record review on 12/11/09, the facility failed to maintain accurate documentation of the medication administration record (MAR) for 2 of 6 residents (Resident #1 Lisinopril 20 mg, Atenolol 50 mg and Simvastatin 10 mg and Resident #6 Gemfibozil 600 mg and Carbamazepine 200 mg).	D 231		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN8ADA	A. BUILDING _____ B. WING _____	12/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE HOUSE I	57 VINE STREET RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE